THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

University Health Services
Florida State University
960 Learning Way
Tallahassee, FL 32306-4178
(850) 644-3608
Fax: (850) 644-8958

Student Name (Printed) _____ _____ _____
Last First MI FSUSN/emplID Date of Birth

Patient Disclosure Authorization:

Emergency Contact Name: _____ Relationship to Patient: _____

Address:_____Phone:(__ _____)_____

Do you want your treatment at University Health Services discussed with this person? Yes ☐ No ☐

The staff members of University Health Services consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. **This does not include Psychiatry.**

YOU MAY DISCUSS MY TREATMENT AT UNIVERSITY HEALTH SERVICES WITH:

Note: Accepted relationships include immediate family members such as, mother, father, spouse, and children. The Health Center will not honor disclosure for discussion of medical conditions, test results, and/or treatment plan to departments on campus or relationships other than those stated without proper medical release forms on file.

1._____Relationship _____

2._____Relationship _____

3._____Relationship _____

I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken. I understand that if I revoke this authorization, I must do so in writing by completing a new Patient Disclosure Authorization Form. Unless otherwise revoked, this authorization will remain on file in my electronic record.

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING

1. I understand and acknowledge by signing this document that I give University Health Services permission to file a claim to my health insurance carrier for the purpose of payment for services I have received at UHS. I further understand and agree that UHS may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance, or services not covered by my insurance plan. I understand that it is my responsibility to know what coverage I have under my individual plan. I give UHS permission to place these unpaid balances on my account with Student Financial Services. I am aware that any unpaid balance on my account with Student Financial Services will generate a "hold" being placed on my registration and that I may be assessed service fees on balances not paid by the due date assigned by Student Financial Services.

2. I understand I have a right to revoke this authorization at any time, except for cases where information has already been disclosed to those listed above. I understand that if I revoke this authorization, I must do so in writing by completing a new Patient Disclosure Authorization Form. Unless otherwise revoked this authorization will remain on file in my electronic health record.

Student Signature: _____Date:_____